AGENCY RELOCATION APPROVAL REQUEST FORM
(revised August 5, 2003)

For DASA Use Only

OK NOK NA
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Please complete the information requested below.

RELOCATING AGENCY INFORMATION

Name of Agency

Agency Number

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RELOCATION INFORMATION

Specify the date the relocation has or will occur(ed).

____/____/____

Print the full street address for the new facility.

_____

_____

_____

Print the new mailing address for the new facility if different:

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OK NOK NA

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Will there be new telephone number(s) at the new facility? (Please check all that apply and enter all new number(s) addresses that apply).

☐ Not different, or,

☐ New telephone number: ( ) _____ - _____

☐ New 2nd telephone number: ( ) _____ - _____

☐ New FAX number: ( ) _____ - _____

☐ New TDD number: ( ) _____ - _____

☐ New e-mail: _____

If request concerns a residential treatment facility you must obtain Department of Health (DOH) licensure for the new facility before being granted DASA approval. Check the box that applies at this time.

☐ Copy enclosed ☐ Copy to follow

Please include an up-to-date floor plan showing the use and dimensions of each room and location of the following information:

Windows and doors;

Restrooms;

Floor-to-ceiling walls;

Reception area is separate from living and therapy areas;

Areas serving as confidential counseling rooms;

Adequate space for personal consultation with patient, staff charting, and other activities;

Other therapy and recreation areas and rooms;

Secure, confidential patient records storage; and,

Sleeping rooms, if a residential facility.

Note: The floor plan can be hand drawn. Please ensure it contains the above information. See attached Sample Floor Plan.

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Provide a written description of the intended uses and capacities of buildings.

Also, if your facility is in a multi-use facility, describe how the chemical dependency treatment services will be kept discrete from other programs or services offered at the same site.

For example: Does the agency ensure all staff members are made aware of their responsibilities to Federal Confidentiality Regulations, 42 CFR, Part 2? Have reception staff members been made aware to not disclose the purpose of a chemical dependency patient's visit when there is a common waiting area? Does the chemical dependency treatment part of the services have it's own chemical dependency counselor qualified supervisor or lead? Is chemical dependency treatment provided separately from other types of treatment such as domestic violence or mental health (mental health treatment meaning the provision of mental health treatment to persons who are not chemically dependent or chemical abusers)?

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Please complete and return the enclosed the attached Americans with Disabilities Act (ADA) Checklist for Existing Facilities Form with your response.

DECLARATIONS

I declare the following:

That all permits, licenses, and inspections required by city, county, state, and federal entities are obtained and are current.

That the policy and procedure manuals have been reviewed and the manuals have been revised to reflect any changes that are necessary are to accommodate the agency clinical and business practices at the new location.

That I have read the Privacy Notice located on page 5 of this form.

That the information contained in this request is true, accurate, and complete to the best of my knowledge.

Type or Print Name	**Title**
Signature of administrator or other responsible party	**Date**
Address	**Telephone** **(_____) _____-_____**

Return this original request form, the floor plan for the new site, and the completed ADA Checklist for Existing Facilities to:

Robert Geissinger, Certification Section
Department of Social and Health Services
Division of Alcohol and Substance Abuse
Post Office Box 45330 (Mail Stop 45330)
Olympia, Washington 98504-5330
Telephone: (360) 725-3728; fax: (360) 438-8057
E-mail: geissrs@dshs.wa.gov

If you need technical assistance regarding the relocation approval process, or need a copy of any regulation cited in this request form, please contact Robert Geissinger.

In most cases your request will be reviewed and responded to within 30 days from date of receipt of the required information at DASA.

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☐ Yes ☐ No Did provider notify DASA at least 60 days before the effective date of relocation?

☐ Approved on _____/_____/_____

☐ APSERT Log Entry Made

☐ Fiscal notified if provider address has changed

☐ Facility Name changed when applicable

☐ Data Entry/Form completed

☐ Approval letter completed

Privacy Notice

This notice is provided in compliance with Governor's Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this application or request.

DASA requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.

DASA also requires an applicant to submit the name, address, and telephone number for each owner of 5% or more of the organizational assets. Additionally, we require owners and the administrator to submit copies of the results of a criminal background check conducted by the Washington State Patrol. This information will be used to determine whether a specific person is a qualified applicant under WAC 388-805-065.

Applicants may decide to provide personal contact information (address, or telephone number) in lieu of business contact information. Addresses and telephone numbers identified as personal information and criminal background checks may be disclosed to parties outside of the department without written consent of the involved party.

All information collected as a part of the application or a request for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington 42.17.310(1).

Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for up to six years following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification. Information will be destroyed after that time.

Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.

Please contact Bob Geissinger if you have any questions or concerns. Contact information is provided with this application.

(f:\shared\certification\forms\W937, revised August 5, 2003)